

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: <u>0 3 — 0 0 9</u>	2. STATE: Puerto Rico
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE August 13, 2003	

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN
 ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN
 ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: 1932 (a)(4) of the Act	7. FEDERAL BUDGET IMPACT: a. FFY _____ \$ _____ b. FFY _____ \$ _____
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Page 10 of Attachment 2.2-A ** See Remarks	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Page 10 of attachment 2.2-A <div style="text-align: right; font-family: cursive;"> Puerto Rico (03-009) approved: 02/24/04 effective: 08/13/03 </div>

10. SUBJECT OF AMENDMENT:

Guaranteed Eligibility

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
 ☒ OTHER, AS SPECIFIED:

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 Not submitted to Governor's Office

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO:
13. TYPED NAME: Johnny Rullán, MD, FACPM	
14. TITLE: Secretary of Health	
15. DATE SUBMITTED: September 26, 2003	

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED: SEP 30 2003	18. DATE APPROVED: FEB 24 2004

PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 08/13/03	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Sue Kelly	22. TITLE: Associate Regional Administrator Division of Medicaid and Children's Health

23. REMARKS:

Originally submitted page has been revised, replaced and approved.

Revision: HCFA-PM-91-10 (BPD)
DECEMBER 1991

Attachment 2.2-A
Page 10

State: [Puerto Rico]

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.212 & [] 3.
1902(e)(2) of the
Act, P.L. 99-272
(section 9517) P.L. 101-508
(section 4732)

The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO), or a primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.

___ The State elects not to guarantee eligibility.

___ The State elects to guarantee eligibility.
The minimum enrollment period is ___ months
(not to exceed six).

The State measures the minimum enrollment period from:

- [] The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.
- [] The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.
- [] The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

*Agency that determines eligibility for coverage.

___ x ___ Not Applicable

TN # 03-09
Supersedes TN # 92-10

Effective Date 08/13/03
Approval Date FEB 24 2004